APPENDIX J

SCREENING CRITERIA FOR COMPLAINTS THAT MAY ADDRESS QUALITY OF CARE ISSUES

Virginia Department of Health
Center for Quality Health Care Services and Consumer Protection

The VDH will investigate complaints where the quality of the health care services provided to enrollees by a health maintenance organization (HMO) licensed in Virginia, or one of its contractors, is in question. The quality of health care services provided by an HMO will be reviewed within the context of the enrollee's health plan coverage, mandated benefits, and the laws and regulations governing the provision of health care services provided by the health maintenance organizations and their providers contained within the *Code of Virginia*, 1950, as amended, and the *Virginia Administrative Code*.

Complaints concerning the quality of health care services can generally be applied to the categories that are listed below.

ACCESS TO HEALTH CARE SERVICES

Geographic access limitations to providers and practitioners
Availability of PCPs, specialists, behavioral and mental health providers
PCP after-hour access
Access to urgent care and emergency care
Out-of-network access
Availability and timeliness of provider appointments and provision of services
Availability of outpatient services within the network (to include HHA, hospice, labs, physical therapy, radiation therapy)
Enrollee provisions to allow transfers to other PCPs
Patient abandonment by PCP
Pharmaceuticals (based on patient's condition, use of generic drugs versus brand name drugs)
Access to preventative care (immunizations, prenatal, STDs, alcohol, cancer, coronary, smoking)
Access to HMO complaint and grievance procedures
HMO enrollee notification regarding changes in the EVIDENCE OF COVERAGE and mandated benefits

UTILIZATION MANAGEMENT

Denial of medically appropriate services covered within the enrollee contract
Limitations on hospital length of stays for stays covered within the enrollee contract

Timeliness of preauthorization reviews based on urgency
Inappropriate setting for care i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
Criteria for experimental care
Unnecessary tests or lack of appropriate diagnostic tests
Denial of specialist referrals allowed within the contract
Denial of emergency room care allowed within the contract
Failure to adequately document and make available to the members reasons for denial
Unexplained death
Denial of care for serious injuries or illnesses, the natural history of which, if untreated, are likely to result in death or to progress to a more severe form
Organ transplant criteria questioned

PRACTITIONERS/PROVIDERS

Appropriateness of diagnosis and/or care
Appropriateness of credentials to treat
Failure to observe professional standards of care, state and/or federal regulations governing health care quality
Unsanitary physical environment
Failure to observe sterile techniques or universal precautions
Medical records - Failure to keep accurate and legible records, to keep them confidential and to allow patient access
Failure to coordinate care (Example: appropriate discharge planning)

The Center's expectation would be that HMO members had attempted to resolve their complaints initially by accessing the HMO's internal complaint resolution process and/or their employers' health benefits office prior to bringing their complaints to the Center unless the complaint was so urgent that it placed the patient or others in serious jeopardy.